



DECLARATION OF CONTINUED GOOD HEALTH

MYSHIELD / MYSHIELD PLUS /GLOBAL HEALTH / IDEALMEDICAL

Other Medical Product: (please specify): _____

Please submit this Declaration by: _____

Full Name of Proposer/Insured: _____

NRIC/ID No. of Proposer/ Insured: _____ Policy No. (if applicable): _____

A. Declaration by Proposer/Insured and, if applicable, Dependant(s)/Insured Person(s)

I / We* hereby declare that since the date of signing my / our* application:

1. There has been no change in my / our* health or occupation status; and
2. I / We* have not had or have any intention to undergo any medical procedure or surgery, any medical test or investigation (excluding yearly voluntary health screening) carried out on the recommendation of a doctor; and
3. I / We* have not sought any medical advice or treatment and are not intending to seek medical advice or treatment in the foreseeable future for any medical condition, disability/deformity/defect, symptom or injury.

If you or your Dependant(s)/Insured Person(s) (if applicable) are unable to answer all or any of the above declaration, please state your reason(s) below, noting the declaration number.

*Delete where applicable

B. Declaration

I/We declare that the answers I/we have given are, to the best of my/our knowledge, true and that I/we have not withheld any material information that may influence the assessment or acceptance of my/our application for medical insurance.

I/We agree that this declaration will constitute part of my/our application and that failure to disclose any material known fact(s) by me/us may invalidate the contract.

Declared by the Proposer (and Dependants/Insured Persons, if applicable) on _____ (dd/mm/yyyy)

	Dependant 1 / () Or Spouse/ Partner	Dependant 2 / () Or Child 1	Dependant () / () Or Child 2
Signature of Proposer/Insured	Signature of all Dependants who are 16 years old and above		